

ViSSTA Consent Form - Student Under 18



		Student/Student li	nformation		
Last Name		First Name	Middle Name	Da	ate of Birth
Address (No P.O. Box) Street:			Gender:		
City:	State:	Zip:		Prefer not to	o answer
Phone Numbe	r:		Email:	•	
Race:	American Indian Black or African American Hawaiian Native or Other Pacific Islander White Asian Not Stated Hispanic/Latino: Yes No Unknown Hawaiian Not Stated				
connection with to participate as vaccine or one J school sports. C by a contracted vendor or school proctored through provided with a f	school attendance/ a an unvaccinated or no ohnson & Johnson va OVID-19 screening te vendor or school pers I personnel. Diagnostith a brief telehealth vis	necessary to conduct COVID-19 to school activity. I understand that a con-fully vaccinated student (fully vaccine) and that refusing to give austing will be conducted using a poonnel. Any needed confirmatory oc testing (including testing of close sit with a contracted vendor, in addinaxNOW test prior to testing. I conitial):	uthorizing COVID-19 testi- accinated is 2 weeks after thorization will prevent my oled PCR testing method. "follow-up" testing will be contacts), may be condu- lition to utilizing PCR testi	ng for my stude the second Pfi y student athlet Screening test conducted by acted using Bina ng. I understar	ent athlete is required zer or Moderna e's participation in ting will be conducted either a contracted axNOW antigen tests and that I must be
program. I under pool of which my	rstand this test will be student is a member	mens to conduct pooled COVID-19 provided at <u>no cost</u> to my student will be reported to designated schotton that would identify my studen	or me. I understand that a ool personnel, and may b	aggregate poole	ed test results for any
follow-up tests o	n my student. I unders sult will be reported to	ol that returns a positive result, I a stand this testing will be provided a designated school personnel and	at no cost to my student o	r me. I understa	and that my student's
	t I can change my mir	nd and cancel this permission at a cel this permission for COVID-19 to			
Print Student Na	me	Stud	ent Signature	<u> </u>	Date
Print Parent Nan	ne		nt Signature/Relationship	to Student	 Date

Chesapeake Public Schools Health Services will maintain a copy of this consent form according to existing state and federal records retention laws and will only provide COVID-19 Testing to individuals who have a completed consent form on file.